General

Guideline Title

Occipital condyle fractures. In: Guidelines for the management of acute cervical spine and spinal cord injuries.

Bibliographic Source(s)

Theodore N, Aarabi B, Dhall SS, Gelb DE, Hurlbert RJ, Rozzelle CJ, Ryken TC, Walters BC, Hadley MN. Occipital condyle fractures. In: Guidelines for the management of acute cervical spine and spinal cord injuries. Neurosurgery. 2013 Mar;72(Suppl 2):106-13. [51 references] PubMed

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The rating schemes used for the strength of the evidence (Class I-III) and the levels of recommendations (Level I-III) are defined at the end of the "Major Recommendations" field.

Recommendations

Diagnostic

Level II

- Computed tomographic (CT) imaging is recommended to establish the diagnosis of occipital condyle fractures (OCF).

Level III

- Magnetic resonance imaging (MRI) is recommended to assess the integrity of the craniocervical ligaments.

Treatment

Level III

- External cervical immobilization is recommended for all types of OCFs. More rigid external immobilization in a halo vest device should be considered for bilateral OCF.
- Halo vest immobilization or occipitocervical stabilization and fusion are recommended for injuries with associated atlantooccipital ligamentous injury or evidence of instability.

Summary

OCF is an uncommon injury and requires CT imaging to establish the diagnosis. Patients sustaining high-energy blunt craniocervical trauma, particularly in the setting of loss of consciousness, impaired consciousness, occipitocervical pain or motion impairment, and lower cranial nerve deficits, should undergo CT imaging of the craniocervical junction. Untreated patients with OCF can develop lower cranial nerve deficits that usually recover or improve with external immobilization. Nonsurgical treatment with external cervical immobilization is sufficient in nearly all types of OCF. Bilateral OCF injuries should prompt consideration for more rigid external immobilization in a halo vest device. Surgical treatment (craniocervical internal fixation and fusion) may be indicated in patients with OCF who have overt instability, neural compression from displaced fracture fragments, or who have associated occipital-atlantal or atlantoaxial injuries.

Definitions:

Rating Scheme for the Strength of the Evidence: Modified North American Spine Society Schema to Conform to Neurosurgical Criteria as Previously Published and for Ease of Understanding and Implementation: Levels of Evidence for Primary Research Question[a]

Class	Therapeutic Studies: Investigating the Results of Treatment	Diagnostic Studies: Investigating a Diagnostic Test	Clinical Assessment: Studies of Reliability and Validity of Observations, Including Clinical Examination, Imaging Results, and Classifications
I	High-quality randomized controlled trial with statistically significant difference or no statistically significant difference but narrow confidence intervals	Testing of previously developed diagnostic criteria on consecutive patients (with universally applied reference "gold" standard)	Evidence provided by 1 or more well-designed clinical studies in which interobserver and intraobserver reliability is represented by a Ä, statistic ≥0.60 or an intraclass correlation coefficient of ≥0.70
	Systematic review[b] of Class I randomized controlled trials (and study results were homogeneous[c])	Systematic review[b] of Class I studies	
II	Lesser-quality randomized controlled trial (e.g., <80% follow-up, no blinding, or improper randomization)	Development of diagnostic criteria on consecutive patients (with universally applied reference "gold" standard)	Evidence provided by 1 or more well-designed clinical studies in which interobserver and intraobserver reliability is represented by a Ä, statistic of 0.40–0.60 or an intraclass correlation coefficient of 0.50–0.70
	Prospective[d] comparative study[e]	Systematic review[b] of Class II studies	
	Systematic review[b] of Class II studies or Class I studies with inconsistent results	Study of nonconsecutive patients; without consistently applied reference "gold" standard	
	Case-control study[g]	Systematic review[b] of Class III studies	
	Retrospective[f] comparative study[e]	Case-control study	
	Systematic review[b] of Class II studies		
III	Case series[h]	Poor reference standard	Evidence provided by 1 or more well-designed clinical studies in which interobserver and intraobserver reliability is represented by a Ä, statistic of <0.40 or an intraclass correlation coefficient of <0.50
	Expert opinion	Expert opinion	

[a]A complete assessment of quality of individual studies requires critical appraisal of all aspects of the study design.

[b]A combination of results from 2 or more prior studies.

[c]Studies provided consistent results.

[d]Study was started before the first patient enrolled.

[e]Patients treated 1 way (e.g., halo vest orthosis) compared with a group of patients treated in another way (e.g., internal fixation) at the same institution.

[f]The study was started after the first patient was enrolled.

[g]Patients identified for the study on the basis of their outcome, called "cases" (e.g., failed fusion), are compared with those who did not have outcome, called "controls" (e.g., successful fusion).

[h]Patients treated 1 way with no comparison group of patients treated in another way.

Levels of Recommendation

Level I	Generally accepted principles for patient management, which reflect a high degree of clinical certainty (usually this requires Class I evidence which directly addresses the clinical questions or overwhelming Class II evidence when circumstances preclude randomized clinical trials)
Level II	Recommendations for patient management which reflect moderate clinical certainty (usually this requires Class II evidence or a strong consensus of Class III evidence)
Level III	Other strategies for patient management for which the clinical utility is uncertain (inconclusive or conflicting evidence or opinion)

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Occipital condyle fractures

Guideline Category

Diagnosis

Management

Treatment

Clinical Specialty

Neurological Surgery

Orthopedic Surgery

Radiology

Intended Users

Advanced Practice Nurses

Hospitals

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To update the medical evidence on the diagnosis and treatment of occipital condyle fracture (OCF) since an earlier publication

Target Population

Patients sustaining blunt craniocervical trauma at risk for an occipital condyle fracture (OCF)

Interventions and Practices Considered

Diagnosis

1. Computed tomographic (CT) imaging
2. Magnetic resonance imaging (MRI)

Treatment/Management

1. External cervical immobilization
2. Halo vest immobilization
3. Occipitocervical stabilization and fusion

Major Outcomes Considered

- Diagnostic utility of computed tomography and magnetic resonance imaging
- Improvement in neurological deficits

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Search Criteria

A National Library of Medicine (PubMed) computerized literature search of publications from 1966 to 2011 was performed using the following headings: occipital bone and fracture (spinal, skull, or fracture alone), and led to 2105 and 71,182 citations, respectively. A subset of 235 citations contained both headings. The bibliographies of the identified articles were scanned to identify additional citations. The articles were reviewed using the following criteria for potential inclusion in diagnosis: human subjects, type of fracture, and tomographic or plain radiographic findings. The articles were separately considered for inclusion in treatment within the following parameters: human subjects, type of fracture, management, and outcome. The observations from all of the citations were combined because the usual methods for analysis were precluded by the infrequent occurrence of this injury type. Fifty-one articles met the selection criteria. All but 2 articles contained Class III medical evidence of either single case studies or case series. The 2 exceptions were prospective studies to evaluate the use of clinical criteria in blunt trauma patients to prompt computed tomography (CT) imaging of the skull base. The duration of follow-up in the clinical articles ranged from not reported to 5 years. The data provided by these reports were compiled and make up the basis for this guideline.

Number of Source Documents

Fifty-one articles met the selection criteria; 44 are summarized in Evidentiary Table format (refer to the table in the original guideline document).

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Rating Scheme for the Strength of the Evidence: Modified North American Spine Society Schema to Conform to Neurosurgical Criteria as Previously Published and for Ease of Understanding and Implementation: Levels of Evidence for Primary Research Question[a]

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[h]Patients treated 1 way with no comparison group of patients treated in another way.

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Selected articles were carefully reviewed by the authors. An evidentiary table was created (refer to the table in the original guideline document) that reflected the strengths and weaknesses of each article.

On occasion, the assessed quality of the study design was so contentious and the conclusions so uncertain that the guideline authors assigned a lower medical evidence classification than might have been expected without such a detailed review. In every way, adherence to the Institute of Medicine's criteria for searching, assembling, evaluating, and weighing the available medical evidence and linking it to the strength of the recommendations presented in this document was carried out.

Articles that did not achieve immediate consensus among the author group were discussed extensively until a consensus was reached. Very few contributions required extensive discussion. Most articles were easily designated as containing Class I, II, or III medical evidence using the criteria set forth by the author group at the initiation of the literature evaluation process (see the "Rating Scheme for the Strength of the Evidence" field).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The current author group was selected for its expertise in spinal surgery (both neurosurgical and orthopedic), neurotrauma, clinical epidemiology, and, in several cases, prior experience with guideline development. The topics chosen for inclusion in this iteration of these guidelines are contemporary and pertinent to the assessment, evaluation, care, and treatment of patients with acute cervical spine and/or spinal cord injuries.

Rating Scheme for the Strength of the Recommendations

Levels of Recommendation

Level I	Generally accepted principles for patient management, which reflect a high degree of clinical certainty (usually this requires Class I evidence which directly addresses the clinical questions or overwhelming Class II evidence when circumstances preclude randomized clinical trials)
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Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Not stated

Description of Method of Guideline Validation

Not applicable

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Accurate diagnosis and treatment of occipital condyle fractures (OCFs)

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- Medical evidence-based guidelines are not meant to be restrictive or to limit a clinician's practice. They chronicle multiple successful treatment options (for example) and stratify the more successful and the less successful strategies based on scientific merit. They are not absolute, "must be followed" rules. This process may identify the most valid and reliable imaging strategy for a given injury, for example, but because of regional or institutional resources, or patient co-morbidity, that particular imaging strategy may not be possible for a patient with that injury. Alternative acceptable imaging options may be more practical or applicable in this hypothetical circumstance.
- Guidelines documents are not tools to be used by external agencies to measure or control the care provided by clinicians. They are not medical-legal instruments or a "set of certainties" that must be followed in the assessment or treatment of the individual pathology in the individual patients we treat. While a powerful and comprehensive resource tool, guidelines and the recommendations contained therein do not necessarily represent "the answer" for the medical and surgical dilemmas faced with many patients.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Mobile Device Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Identifying Information and Availability

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Mar

Guideline Developer(s)

American Association of Neurological Surgeons - Medical Specialty Society

Congress of Neurological Surgeons - Professional Association

Source(s) of Funding

Congress of Neurological Surgeons

Guideline Committee

Guidelines Author Group of the Joint Section of Disorders of the Spine and Peripheral Nerves of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons

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Financial Disclosures/Conflicts of Interest

The authors have no personal financial or institutional interest in any of the drugs, materials, or devices described in this guideline.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) and EPUB for eBook devices from the Neurosurgery Web site .

Availability of Companion Documents

The following are available:

- Foreword. Guidelines for the management of acute cervical spine and spinal cord injuries. Neurosurgery 2013;72(3):1. Electronic copies: Available in Portable Document Format (PDF) from the Neurosurgery Web site .
- Commentary. Guidelines for the management of acute cervical spine and spinal cord injuries. Neurosurgery 2013;72(3):2-3. Electronic copies: Available in PDF from the Neurosurgery Web site .
- Introduction to the guidelines for the management of acute cervical spine and spinal cord injuries. Neurosurgery 2013;72(3):5-16. Electronic copies: Available in PDF from the Neurosurgery Web site .
- Methodology of the guidelines for management of acute cervical spine and spinal cord injuries. Neurosurgery 2013;72(3):17-21. Electronic copies: Available in PDF from the Neurosurgery Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on July 9, 2013. The information was verified by the guideline developer on October 3, 2013.

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